lication in CALIFORNIA MEDICINE. On motion duly made and seconded, it was voted to refer this study to the journal for consideration for publication.

Doctor Davis also requested a vote of commendation for Doctor James C. Doyle for his having moderated the recent A.M.A.-C.M.A. Conference on Quackery, much of which had to do with cancer. By voice vote the Council concurred.

23. *Attendance at Council Meetings:*

Doctor MacLaggan suggested that the president of the California Hospital Association be invited to attend Council meetings. On motion duly made and seconded, it was voted to extend this invitation.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 6:00 p.m.

CARL E. ANDERSON, M.D., *Chairman*
MATTHEW N. HOSMER, M.D., *Secretary*

Principles of a Sound Program for Medical Care

An ad hoc committee was appointed by the Council to develop principles which the medical profession can adopt as a sound and supportive basis for the provision of medical services to those persons who are not able to meet the cost of such services from their usual resources.

This committee met on September 28 and agreed on the principles listed below as a starting point for development of a program which would (1) assure the delivery of needed medical services to the people, (2) assure the maintenance of sound scientific tenets, and (3) outline methods by which such services could be financed.

1. Financial responsibility for the care of the patient is initially his own. Should financial resources be unavailable to the patient or his family, responsibility then flows to the local community and from there to the county, to the state and, only as a last resort, to federal government. Government at all levels has a financial responsibility and a role to play in the provision of funds for the care of those who are in need of medical services and who lack the resources to purchase adequate health care protection.

2. The voluntary insurance programs through prepayment offer the most effective and versatile approach to financing health care. They already have, in the past several decades, demonstrated unprecedented growth and expansion and they possess the potential of further expansion if given the opportunity of refinement, enrichment and experimentation.

3. These principles have already demonstrated their versatility and effectiveness in the care of millions of Americans, including the medically needy. For example, the Kerr-Mills approach is in keeping with this method of financial responsibility in the medically needy group.

In some areas, however, especially where state enabling legislation is not yet sufficiently broad, it appears that local and state programs need to be extended to additional beneficiaries. Existing needs for broadening such coverage do not negate the philosophy of financial responsibility recognized in these programs.

4. Additional groups including the financially or medically needy may be assisted in financing the costs of medical care services through tax deductions, tax credits or other incentives. These could be allowed to the patient or to members of his family who assume the financial responsibility for his medical care even though they may not claim the patient as an exemption under federal or state income tax laws.

5. Another approach for the medically needy would be through cash allowances for premiums for voluntary prepaid health insurance through a sliding scale of cash allowances adequate to permit the purchase of sound health care protection.

RESOLUTION NO. 1

WHEREAS, the 87th Congress declined adoption of King-Anderson legislation; and

WHEREAS, programs for assisting the needy aged or the medically indigent aged need further study, refinement and extension; and

WHEREAS, the Kerr-Mills program is the law of the land and has been approved by the medical profession and has been successful in some areas but has not had an opportunity to demonstrate its effectiveness in other areas; and

WHEREAS, enabling legislation has been adopted in some states while not in others and in some of those areas where enabling legislation has been enacted it may require modification or broadening on the basis of experience to be more effective and efficient; and

WHEREAS, Kerr-Mills implementation has lagged or been inadequate in some areas because political figures have, for reasons of their own, seen fit to deter such implementation or physicians, also for reasons of their own, have not encouraged or stimulated state and local participation; and

WHEREAS, Kerr-Mills legislation is in accord with principles approved by the American Medical Asso-

ciation and is legislation already on the federal statute books which is capable of stimulating and supplementing local and state health care programs for the needy or near-needy; now, therefore, be it

Resolved: That the American Medical Association use its good offices and influence in urging all component associations to strengthen, expand or otherwise modify Kerr-Mills enabling legislation in those states where such legislation is needed and has been enacted, to the end that effective and valuable methods of health care may be provided to aged recipients, where the need exists, under terms approved by physicians; and be it further

Resolved: That improvements in existing Kerr-Mills enabling legislation should be sought; for example, in (a) lowering waiting periods for eligibility, (b) establishment of a dollar deductible for applicants rather than a time period, (c) removal of administrative regulations which debar some applicants from eligibility if they have been receiving aid from welfare funds, and other means, all of which should be explored by the various states; and be it further

Resolved: That the American Medical Association urge those component associations in areas where Kerr-Mills enabling legislation has not yet been enacted but where local and state programs need further stimulus or financial help from Federal "grants-in-aid" to use their utmost efforts in securing the adoption of adequate enabling legislation for this purpose.

RESOLUTION NO. 2

WHEREAS, the financing of medical and health services has in recent history become a political consideration; and

WHEREAS, voluntary prepayment and insurance plans have been developed in the past thirty years as a means of permitting people to budget for these costs and these plans have been spectacularly approved and accepted by the American people; and

WHEREAS, universal inflationary forces have required that the cost of providing health care services be increased, and such increases in the cost of prepayment and insurance coverage have had the double effect of (1) decreasing the coverage available where the cost paid does not keep pace with the cost of services to be provided, and (2) creating fuel for political claims that costs are at a level requiring governmental seizure of the entire field of furnishing and financing health care; and

WHEREAS, political figures recognize the cost factor in providing prepayment as a political factor but to date have given little or no recognition to the costs involved to individual taxpayers; now, therefore, be it

Resolved: That the American Medical Association through its Board of Trustees, its Councils, its staff and consultants use every possible effort to secure federal enactment of legislation which will permit tax deductions, tax credits or other monetary incentives to those who assume the cost, including those of adequate voluntary prepaid plans, of providing health care services for the needy or near-needy aged group of citizens.

RESOLUTION NO. 3

Resolved: That the American Medical Association endorse the principle in the care of the medically needy which will permit allowances for premiums for voluntary prepaid health insurance adequate to purchase sound health care. The amount of such allowances should be based on a sliding scale of income and in keeping with the principle that the government at all levels, national, state and local, has some financial responsibility in the care of the medically needy. Determination of need and administration should be at the local level.

PROPOSED AMENDMENTS TO CONSTITUTION

Amendments to the Constitution of the California Medical Association are required to lie on the table for one year before being voted upon. Six proposed amendments to the Constitution were introduced in the 1962 House of Delegates. Under the terms of the Constitution, these were subject to review by the Reference Committee in the 1962 House of Delegates and will also be reviewed by Reference Committee No. 4 in the 1963 House before being voted upon in that session. In five instances the 1962 Reference Committee made specific recommendations which were adopted by the House and are shown following the proposals.

In some instances the Reference Committee suggested that proposed amendments to the By-Laws, which need lie on the table only twenty-four hours, also be deferred until 1963 because of their association with constitutional amendments on the same subject. In the section on By-Law Amendments following this section, such deferral will be noted.

The following Amendments to the Constitution were offered in 1962, all of them placed on the table for definitive action in 1963.

1962 AMENDMENTS

Six proposed amendments to the Constitution were introduced in the 1962 House of Delegates. They were reviewed by Reference Committee No. 4